SUCCESSFUL AGING

Community Resources for Frail Older Patients

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The goal of community-based services for frail older patients is to help them achieve the greatest degree of functional ability and independence. The services available include case management, geriatric assessment, adult day health care, home health services, and the Program for All-inclusive Care for the Elderly (PACE). Definitive criteria for referral have not been established, but without some targeting, the efficacy of these services remains uncertain. Targeting criteria identified include dependency in 2 or more activities of daily living, no family support, dementia, many long-term illnesses, and many hospital stays. Although efficacy and cost-effectiveness remain uncertain, patients, families, and physicians generally report these services to be helpful.

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Older patients are much more likely than young to require community resources when they are ill. Young and middle-aged adults usually seek medical attention for an acute illness that, in most instances, resolves quickly, and the patients resume their normal lives. Geriatric patients have chronic illnesses, multiple medical problems, slow recovery often with decreased mobility and function, and associated social and psychological problems, especially if they live alone or with a sick spouse. Thus, social services and other community resources are often needed. In the past 30 years, older patients faced with progressive weakness and disability had few options available to help them remain at home. In addition, because nursing home placement was reimbursable (but in-home personal care services were not), physicians and families often took the more economical route and placed patients in nursing homes when other alternatives might have served them better. We will briefly discuss some of the community resources now available to frail older patients that often will allow them to remain at home or at least delay admittance to a hospital or nursing home.

We will also describe those patients appropriate for different services and how these services can help maintain the greatest degree of independence possible for the patients. It should be noted that the theme for this edition is successful aging. Why, then, an article on frail older patients? The answer is that geriatric medicine looks for those strengths and resources within patients, families, and the community that can increase the patients' potential for success. Stroke patients who progress from bedbound to chair and finally to walking should be recognized as a variant of successful aging.

Community Services Available

Case Management

The primary goal of case management is to identify and to coordinate the community services persons may need to live at home in the least restrictive environment possible. Case-management programs typically include the following services: evaluation and supervision of patients' health, functionality, and psychosocial status; advocacy; referral to services; coordination of services; and consultation with physicians. Services can be difficult to access, and the needs of older people can change as their conditions change. Case managers, who are usually nurses or social workers, not only navigate their way through the fragmented service community, but they can also tailor services to the individual needs of their clients.[1]

The term "case management" is now being used in a wide variety of settings, and the goals may differ in

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each setting. For example, a case manager at a nursing home or hospital will focus on the short-term goals of discharge planning and the arrangement of home care services immediately following the nursing home or hospital stay. They do not usually have responsibility for follow-up care or discharge. The responsibilities of case managers working for managed care groups may have the additional responsibility of managing the resources within the health care program with the goal of minimizing expenditures for services. A community-based case manager, common in many local and state-funded programs, will not only arrange services for a patient but will actively monitor those services and the patient's needs.

Case management can be an invaluable adjunct for physicians by helping to manage complicated older patients in the community. A number of case-management programs provided by Medicare managed care organizations assign case managers to physician practices, allowing physicians to readily access these services in their office setting. Case management can also be accessed through hospital social work or nursing departments or a local area agency on aging.

With the exception of private long-term care insurance, there is no third-party coverage for case management as a discrete service. Traditional Medicare programs do not cover case management services. Most TEFRA Medicare managed care programs will have case managers. Publicly funded services are available based on financial eligibility. For Medicaid recipients in many counties, these services are free. Private case management is also widely available, with costs ranging between $55 and $95 per hour.

Geriatric Assessment

Geriatric assessment is a multidisciplinary effort to address the medical, functional, social, and psychological needs of older people with multiple problems. These assessments usually include evaluations by workers in several disciplines such as medicine, nursing, and social work. Some assessment programs include occupational and physical therapy, pharmacy, and psychology. The goals of a geriatric assessment are to identify any treatable problems, to maximize patients' functional status, and to recommend the most effective care to achieve the best outcome. Most assessment services are targeted toward frail older persons living at home. There are assessment services specifically for patients with dementia. Most assessment services involve consultation only, although some provide follow-up care for a specified period of time.

Not all communities have geriatric assessment services. Many are associated with a geriatric department in university medical centers or with geriatric community programs. Some dementia-specific federally funded assessment services help in establishing diagnoses and developing treatment plans for patients with possible dementia.

Primary care physicians should consider a referral for geriatric assessment when they need a second opinion about a patient's problems, a change in a patient's domestic setting is being considered, or a substantial but unexplained change in a patient's functional or mental status has occurred.

More than a decade ago, remarkable benefits were reported from inpatient geriatric evaluations, including shorter hospital stays, improved functional status, and fewer medications.[2] Other evaluations of the benefits of geriatric assessment, however, have been contradictory. At the very least, as Campion has pointed out, "the physicians, nurses, family, and the patient may well see value in the way an experienced geriatrics team helps with complicated problems such as incontinence, confusion, immobility, and complex drug interactions."[3]

Geriatric assessment services are frequently covered by Medicare, particularly initial evaluations. As with other geriatric services, payment depends on the setting. For example, many assessment services for patients with dementia may be funded separately at a state or local level.

Adult Day Health Care

Adult day services provide a variety of facility-based rehabilitation and social and support services to functionally impaired persons. Patients typically attend such centers at least several days a week. There are an estimatcd 2,000 centers across the country serving more than 70,000 people. The major objectives of these programs are to provide an alternative to institutionalization, to increase functional abilities, and to provide respite for caregivers.[1]

Services vary depending on the center. Some day care centers are targeted to specific populations, such as those with psychiatric disorders, dementia, or developmental disabilities. Some centers provide care for each of these groups at the same site but with separate programming. Basic services include meals, transportation, personal care, and recreation. Many centers also include nursing, rehabilitation, social services, case management, and limited medical services such as podiatry. Some communities have comprehensive outpatient rehabilitation facilities that focus on rehabilitation. They provide a coordinated approach to outpatient rehabilitation that includes physical therapy, occupational therapy, social work, nursing, speech, and psychological services as needed.

The target population for this service includes patients who have one or more of the following conditions: impairment in activities of daily living such as eating, bathing and toileting; impairment in mobility, including those who are wheelchair-bound; and cognitive impairment due to developmental disability or dementia. Payment for day care services is usually on a sliding scale with the daily cost being about $50 per day. Medicaid covers these services in most communities.

Home Health Services

Home health care provides a variety of services that include skilled nursing, rehabilitation, social work, and personal care. The term "home health care" refers to the professional nursing, physical and occupational therapy, and social work services provided on a per-visit basis by a licensed certified agency. Typically, home health care is begun after a lengthy hospital stay and is limited to a specified period of time

Shortened hospital stays and managed care influences, however, have encouraged more flexible uses of home health care, such as following ambulatory surgery. Hospital discharge planners and case managers arrange post-hospital home care services, while physicians' offices can contact a home health agency directly from the primary care setting. Physicians' orders are required for all skilled services. Medicare, Medicaid, and private insurance cover skilled services as long as they are considered medically necessary.

Home care services include the personal care, homemaking, and chore services that are often the backbone of long-term care in the home. Assistance with bathing, grooming, dressing, meals, and housekeeping for a few hours a day can make the difference between staying in the community or going to a nursing home. Yet, this sector of home care is not reimbursed by Medicare or private insurance except under limited circumstances. Unless patients are eligible for Medicaid, they and their familes pay for these services themselves. Home care workers can be hired privately or through a home care agency. Although agency charges are more expensive, the agency handles all screening, hiring, training, supervision, and replacement of the workers.[4]

It is estimated that at least 11 million people of all ages use home care. There are at least 15,000 agencies in the United States providing these services. Agencies may be independent or affiliated with a hospital or managed care group.[4] Independent agencies can be located by contacting the local area agencies on aging.

Program for All-inclusive Care for the Elderly

The Program for All-inclusive Care for the Elderly (PACE) is a Medicare or Medicaid managed care capitated program that integrates primary medical care, social day care, home care, and rehabilitation into one integrated system. Currently there are 11 cities with fully developed PACE sites. Another 8 cities have programs in development, and 31 organizations are doing feasibility studies for the development of a PACE site.[5,6]

To be eligible for this program, a patient must meet nursing home admission criteria. The goal is to keep frail older persons living at home—out of nursing homes and out of hospitals. Evaluation of these services has shown decreased time in the hospital and high client and family satisfaction. Further quality review of these services is being done. Many managed care organizations are beginning to look at this model for possible incorporation into their services for their more at-risk patients.

Who Should Be Referred to Services?

Who should be referred to these services is not always clear. A number of studies have attempted to answer this question by evaluating the targeting criteria—that is, identifying which subgroups of the elderly are most likely to benefit from a service. Some of the criteria identified are dependency in two or more activities of daily living, no family support, dementia, multiple chronic diseases, and repeat hospital stays. If patients do not meet the criteria, the efficacy of any of the geriatric services is questionable.[7]

More recently, an attempt has been made to evaluate those people at risk in Medicare managed care programs. This instrument, the "probability of repeated admissions," consists of eight close-ended questions that can be asked by mail or by telephone. These questions focus on patients' self-report of health, recent hospital admissions, and social support.[8–11]

For community physicians, however, patients who might benefit from increased services include those meeting the targeting criteria but may also include patients who may need more than basic medical interventions and those who are being considered for nursing home placement. Patients with dementia, poor functional status, and weak social support systems are also good candidates for these community services.

Financing of Services

Financing varies for these services, depending on patients' financial status and individual health insurance. Many of the services are covered by Medicaid, including case management, day care, and home care, although some restrictions may apply. Day care is covered by many Medicaid programs, but not by Medicare. Medicare does, however, cover comprehensive outpatient rehabilitation services because these are seen as short-term services.[12]

Most middle-income people do not have insurance that covers these services and usually have to pay for them themselves. As mentioned, Medicare will cover short-term homecare, usually after a long-term hospital stay, but will not finance long-term personal care unless there is a specific skilled-nursing need attached to the service.

Efficacy of Services

Many studies have focused on the effectiveness of the above services, with varying conclusions.[13–20] A meta-analysis tended to show improvement in selected aspects of medical care.[13] These improvements included increased identification of unrecognized medical and psychosocial problems, reduced medications, improved functional status, fewer hospital stays, and increased

survival. The effectiveness studies have been hampered, however, by the diversity of the assessment programs, the differences of the populations studied, and the type of data collected.

The PACE data suggest that this managed care model shortened hospital stays and decreased nursing home care, which may reflect a cost savings. Comparisons with other programs are difficult to assess, however, because of the complex nature of the PACE progams.[5, 6]

A literature review was done of 32 studies of community-based, long-term-care programs that included home care, ADIC, and other coordinated packages of services.[20] In almost all cases, these services did not increase survival and did not enhance or slow the rate of deterioration of functional status. There was a tendency for higher client and caregiver satisfaction, although this tended to decrease if the services extended beyond a certain time. Cost-effectiveness is still not adequately evaluated.

Conclusion

Many communities now have an array of geriatric community services available to physicians. The goal of these services is to help patients achieve the greatest degree of functional ability and independence. Although data on outcomes are highly varied, these services can be a valuable adjunct to the care of targeted frail older persons. In addition to private physicians and social service agencies, managed care organizations are using these services, particularly case management for their high-risk clients. Physicians can benefit from these services in the following ways:

- By increased information on patients' functional and psychosocial status through geriatric assessment.
- By assistance in directing their patients to useful community resources through case managers.
- By increasing patient and family satisfaction with their current health care.

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